I. PROPOSAL OVERVIEW

The Local Choice Health Benefits Program was created exclusively for local governments, authorities, school divisions and constitutional officers. Launched in July 1990, the program is managed by the Commonwealth of Virginia's Department of Human Resource Management (DHRM), the same team of administrators that manage the State's employee health benefits program.

HOW THE LOCAL CHOICE (TLC) PROGRAM WORKS

CHOICE OF PLANS – STATEWIDE AND REGIONAL

TLC offers one of the most comprehensive selections of plans available in the state that include four Key Advantage plans, a High Deductible Health Plan and a Regional HMO. Most employers may choose from several combinations of the following plans:

STATEWIDE KEY ADVANTAGE PLAN OPTIONS:

Key Advantage self-funded medical coverage is administered by Anthem Blue Cross and Blue Shield. Dental coverage is administered by Delta Dental of Virginia. Behavioral health and our Employee Assistance program (EAP) are administered by ValueOptions, Inc. and the outpatient prescription drug coverage is administered by Medco Health Solutions, Inc.

In all statewide self-funded plans, admission to a hospital for an inpatient stay must be approved in advance, or within 48 hours in the case of an emergency or the birth of a child. The plans do not require specialist referrals, but you are encouraged to have behavioral health treatments preauthorized to assure medical necessity and that providers are in-network.

You may choose from among Key Advantage Expanded, Key Advantage 200, Key Advantage 300 and Key Advantage 500. All four options are preferred provider organization (PPO) plans offering routine medical care and specialist care without referral requirements. They also include preventive medical care, immunizations, outpatient three-tier prescription drugs, behavioral health and EAP services, and preventive, primary and major restorative dental benefits with orthodontia. Vision coverage is available only with Key Advantage Expanded.

- ✓ **Key Advantage Medical Services**
  While members receive the highest level of benefits when visiting an in-network provider, the Key Advantage plans provide out-of network coverage for covered medical services. Key Advantage Expanded offers out-of-network services at a 25% reduction in reimbursement, while Key Advantage 200, 300 and 500 provide out-of-network services with additional deductibles and/or coinsurance. In all statewide plans, the Anthem BlueCard PPO and BlueCard Worldwide networks allow for in-network medical care outside of Virginia, without penalty, through BlueCard participating providers.

- ✓ **Key Advantage Behavioral Health Services**
  As with medical services, members receive the highest level of benefits when visiting an in-network provider for behavioral health services. All outpatient provider copayments are considered at the primary care physician level. Key Advantage Expanded offers out-of-network services at a 25% reduction in reimbursement, while Key Advantage 200, 300 and 500 provide out-of-network services with additional deductibles and/or coinsurance. Although not required, members are encouraged to contact ValueOptions for prior authorization of benefits to verify medical necessity and avoid a 25% reduction in plan payment or increased deductibles and coinsurance for services received outside the network. Under the EAP, members receive up to four visits per incident at no cost. The EAP is only available in-network through ValueOptions, Inc.

- ✓ **Key Advantage Dental Benefits**
  Preventive, primary and major restorative dental benefits with orthodontia are provided through Delta Dental Plan of Virginia. Delta Dental provides a national network of dental providers. Members are not required to use an in-network provider for dental services. However, members pay less when using an in-network dentist. Non-network providers may balance bill members and may not offer negotiated discounts.

- ✓ **Key Advantage Outpatient Prescription Drug Benefits**
  The outpatient prescription drug program is administered by Medco Health Solutions, Inc. Members are not required to use an in-network provider for prescription drug services. However, members pay less when using an in-network pharmacy. Non-network providers may balance bill members and may not offer negotiated discounts. To maximize prescription drug savings, Home Delivery mail service is available.

Outpatient prescription drugs are divided into three-tiers or categories. Members pay the appropriate copayment through the Medco pharmacy network by tier. The three-tier prescription drug benefit is a mandatory generic program. If a generic drug is available and you purchase a brand name drug, you pay the appropriate co-pay and the difference in brand and generic cost. To determine in which tier a prescription drug falls, go to www.medco.com. The chart below illustrates drug tiers.

	First Tier Co-payment Typically Generic Drugs	**Second Tier** Co-payment Lower Cost Brand Name Drugs and Some Generic Drugs	**Third Tier** Co-payment Typically Higher Cost Brand Name Drugs
Participating Retail Pharmacy Per 34-day supply	$15	$20	$35
Home Delivery Pharmac Up to 90-day supply	$30	$40	$70

NEW HIGH DEDUCTIBLE HEALTH PLAN OPTION:

In 2006-07, TLC employers may select our new High Deductible Health Plan (HDHP) that is Health Savings Account (HSA) compatible. **While the HDHP will be compatible with an HSA, TLC will not provide the HSA account. Participants will have the flexibility to contract with a bank or financial institution offering an HSA.**

Medical, behavioral health and EAP, and outpatient prescription drugs for this new plan are administered by Anthem Blue Cross and Blue Shield. Preventative medical care for the HDHP will be covered with no deductible or coinsurance. All other covered medical, behavioral health and prescription drug services are subject to a $1200 employee and $2400 family plan year deductible with 80/20 coinsurance. ***Dental is also provided and administered by Anthem but is not part of the HDHP.*** The dental product covers preventative, primary and major restorative services and orthodontia. The dental coverage will have a $1500 plan year maximum and a $1500 lifetime orthodontia maximum.

Fourth quarter deductible carry over is not available with the HDHP. The HDHP plan covers in-network only except in the event of an emergency. This

plan includes BlueCard PPO and BlueCard Worldwide for medical and behavioral coverage outside Virginia.

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REGIONAL PLAN OPTION:

Regional HMO service area and plan available:

- ✓ Northern Virginia – Kaiser Permanente (HMO)

A more detailed outline of the service area and benefits may be found in the Kaiser HMO brochure. Medical, behavioral health and EAP, prescription drug and dental coverage are included in the Kaiser HMO plan.

STATEWIDE MEDICARE RETIREE PLAN OPTIONS:

Retirees Not Eligible for Medicare

You may include your retirees not eligible for Medicare in your membership. Retirees must be at least age 55 with 5 years of service with the Local Employer or age 50 with 10 years of service with the Local Employer. They must also be eligible for and receive an annuity payment from your primary retirement vehicle. Retirees not eligible for Medicare have the same plans available to them as your active employee groups. You are not required to contribute to the cost of retiree coverage.

Medicare Eligible Retirees

If you choose to cover your retirees that are not eligible for Medicare you may also provide coverage for your Medicare retirees. We offer Advantage 65 or Advantage 65 with Dental/Vision for Medicare retirees. Medicare Eligible Retirees may not remain in active coverage. If they participate, it must be in one of our Medicare supplemental plans. You are not required to contribute to the cost of retiree coverage.

Local Employers may select only one plan for Medicare eligible retirees. These plans are available if your active employees are enrolled in a statewide self-funded plan and you elect to offer coverage to both Retirees Not Eligible for Medicare and Retirees Eligible for Medicare.

You may offer one of the following plans to your Medicare Retirees:

Advantage 65

Advantage 65 provides supplemental health benefits for your Medicare eligible retirees. A more detailed outline of benefits may be found in the Advantage 65 brochure.

Advantage 65 with Dental/Vision

As a group option, you may elect to add Dental/Vision coverage to Advantage 65. This product provides Advantage 65 coverage plus dental and vision coverage. Anthem Blue Cross and Blue Shield administers both dental and vision coverage, as outlined below:

Dental: The plan pays 100% of Allowable Charge (AC) for diagnostic and preventive services and 80% of AC for primary services. Up to $1200 per member per plan year is payable.

Vision: Once every 24 months, the plan pays up to $40 for one routine eye exam, up to $75 for one pair of frames, up to $50 per pair of single lenses, up to $75 per pair of bifocal lenses, up to $100 per pair of trifocal lenses, and up to $100 for contact lenses.

*****Note: In order for Medicare Eligible Retirees to receive maximum benefits they must have both Parts A and B of Medicare. If prescription drug coverage is desired they should participate in Medicare D. Effective on 1/1/2006, with the availability of Medicare D, prescription drug coverage is no longer available with the TLC Medicare supplemental plans. *****

TLC PLAN CHOICES

The Local Choice program provides three types of coverage: Active Employees, Retirees Not Eligible for Medicare, and Retirees Eligible for Medicare. The program must be offered to your active employees. Retiree-only plans are not permitted. However, you have flexibility in defining active employee status. You may also choose to offer coverage to Retirees Not Eligible for Medicare and Retirees Eligible for Medicare. To assure continuity of coverage, you may not offer coverage to Medicare Eligible Retirees without offering coverage to Retirees Not Eligible for Medicare.

Larger employers may offer employees one plan or a combination of plans. You may choose from:

- ✓ Key Advantage Expanded
- ✓ Key Advantage 200
- ✓ Key Advantage 300
- ✓ Key Advantage 500
- ✓ Regional HMO Plan (if available in your area)
- ✓ High Deductible Health Plan

- Groups with 25 or fewer eligible employees may offer only one benefit plan.

- Groups with 26 to 100 eligible employees may offer up to two plan options.

- Groups with more than 100 eligible employees may offer up to two self-funded plan options plus the HDHP or the Regional HMO, if available in your area.

PRE-EXISTING CONDITIONS WAITING PERIODS

There are no pre-existing condition exclusions in any TLC medical plan. Orthodontic benefits paid under previous coverage will not count against the lifetime maximum orthodontic benefit. TLC does not offer credit for previously satisfied deductibles or out of pocket maximum limits incurred with a prior plan

COMMONHEALTH

The CommonHealth wellness program is a value-added benefit available at no cost to all TLC member groups. (A small charge may be made to the employee for participation in certain programs.) CommonHealth provides medical screenings, health risk appraisals, Baby Benefits (pre-natal risk management), weight loss, and stress management as well as other health and wellness programs. Since wellness programs often can help control claims costs, we strongly encourage you to take advantage of this program. The CommonHealth program is provided and administered by Continental Health Promotion, Inc. and all employees and their dependents covered by any TLC program are eligible to participate.

ADDITIONAL INFORMATION

For additional information on benefit plans offered, please consult the Plan brochures included with this proposal. Detailed information will also be available in the member handbooks. The Local Choice Web site at www.thelocalchoice.virginia.gov provides more detailed information.

II. STATE OF VIRGINIA REGULATIONS

REGULATIONS GOVERNING THE LOCAL CHOICE PROGRAM

The following is a copy of the Virginia Administrative Code governing The Local Choice Program.

CHAPTER 20.

COMMONWEALTH OF VIRGINIA HEALTH BENEFITS PROGRAM

1VAC55-20-10. [Repealed]

1VAC55-20-20. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Accident or health plan" means a plan described in the Internal Revenue Code §105.

"Administrative services arrangement" means an arrangement whereby a third party administrator agrees to administer all or part of the health benefits program.

"Adoption agreement" means an agreement executed between a local employer and the department specifying the terms and conditions of the local employer's participation in the health benefits program.

"Alternative health benefits plans" means optional medical benefits plans, inclusive of but not limited to HMOs and PPOs, which are offered pursuant to the health benefits program in addition to the basic statewide plan(s).

"Basic statewide plan(s)" means the statewide hospitalization, medical and major medical plan offered at a uniform rate to all state employees pursuant to §2.2-2818 of the Code of Virginia.

"Benefits administrator" means the person or office designated in the application and adoption agreement to be responsible for the day-to-day administration of the health benefits program at the local level. The benefits administrator is an employee of the agency or local employer that employs the benefits administrator. The benefits administrator is not an agent of the health insurance plan or the Department of Human Resource Management.

"Coordinated service" means a health care service or supply covered under both the program and another health plan. The coordinated service will be provided under the program only to the extent it is not excluded or limited under the program.

"Coordination of benefits" means the establishment of a priority between two or more underwriters which provide health benefits protection covering the same claims incident.

"Department" means the Department of Human Resource Management.

"Dependent" means any person who is determined to be an eligible family member of an employee pursuant to subsection E of 1VAC55-20-320.

"Director" means the Director of the Department of Human Resource Management.

"Dual membership" means the coverage in the health benefits program of the employee and either the spouse or one dependent. This definition does not include coverage of retirees or employees or their spouses who are otherwise covered by Medicare.

"Effective date of coverage" means the date on which a participant is enrolled for benefits under a plan or plans elected under the health benefits program.

"Employee" means a person employed by an employer participating in the health benefits program or, where demanded by the context of this chapter, a retired employee of such an employer. The term "employee" shall include state employees and employees of local employers.

"Employee health insurance fund" or "health insurance funds" means accounts established by the state treasury and maintained by the department within which contributions to the plan shall be deposited.

"Employer" means the entity with whom a person maintains a common law employee-employer relationship. The term "employer" is inclusive of each state agency and of a local employer.

"Employer application" or "application" means the form, to be provided by the department, to be used by the local employer for applying to participate in the health benefits program.

"Enrollment action" means providing the information, which would otherwise be contained on an enrollment form, through an alternative means such as through the world wide web or through an interactive voice response system, for the purpose of securing or changing membership or coverage in the employee health benefits program. Submitting a properly completed enrollment form and taking an enrollment action through an employee self-service system are used interchangeably to indicate equivalent actions.

"Enrollment form" means the form, to be provided by the department, to be used by participants to enroll in a plan or to indicate a change in coverage.

"Experience adjustment" means the adjustment determined by the department, consistent with its actuarial practices, to premiums for the year in which a local employer withdraws from the plan.

"Family membership" means the coverage in the health benefits program of the employee and two or more eligible dependents.

"Health Maintenance Organization" or "HMO" means an entity created under federal law, "The Health Maintenance Organization Act of 1973" (Title XIII of the Public Health Service Act), as amended, or one defined under state law.

"Health benefits program" or "program" means, individually or collectively, the plan or plans the department may establish pursuant to §§2.2-1204 and 2.2-2818 of the Code of Virginia.

"Health plan" means:

1. A plan or program offering benefits for, or as a result of, any type of health care service when it is:

    a. Group or blanket insurance (including school insurance programs);

    b. Blue Cross, Blue Shield, group practice (including HMOs and PPOs), individual practice (including IPAs), or any other prepayment arrangement (including this program) when;

        (1) An employer contributes any portion of the premium; or

        (2) An employer contracts for the group coverage on behalf of employees; or

        (3) It is any labor-management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan.

2. The term "health plan" refers to each plan or program separately. It also refers to any portion of a plan or program which reserves the right to take into account benefits of other health plans when determining its own benefits. If a health plan has a coordination of benefits provision which applies to only part of its services, the terms of this section will be applied separately to that part and to any other part.

3. A prepaid health care services contract or accident or health plan meeting all the following conditions is not a health plan:

    a. One that is individually underwritten;

    b. One that is individually issued;

    c. One that provides only for accident and sickness benefits; and

    d. One that is paid for entirely by the subscriber.

A contract or policy of the type described in this subdivision 3 is not subject to coordination of benefits.

"Impartial health entity" means an organization, which upon written request from the Department of Human Resource Management examines the adverse health benefits claim decision made by the Commonwealth's Third Party Administrator (TPA). The impartial health entity should determine whether the TPA's decision is objective, clinically valid, compatible with established principles of health care, and appropriate under the terms of the contractual obligations to the covered person.

"Insured arrangement" means an accident or health plan underwritten by an insurance company wherein the department's only obligation as it may relate to claims is the payment of insurance company premiums.

"Independent hearing officer" means an individual requested by the director of the department from a list maintained by the Executive Secretary of the Supreme Court to arbitrate disputes which may arise in conjunction with these regulations or the health benefits program.

"Local employees" or "employees of local governments" means all officers and employees of the governing body of any county, city, or town, and the directing or governing body of any political entity, subdivision, branch, or unit of the Commonwealth or of any commission or public authority or body corporate created by or under an act of the General Assembly specifying the power or powers, privileges or authority capable of exercise by the commission or public authority or body corporate, as distinguished from §§15.2-1300, 15.2-1303 or similar statutes, provided that the officers and employees of a social services department, welfare board, mental health and mental retardation services board, or library board of a county, city, or town shall be deemed to be the employees of local government.

"Local employer" means any county, city, or town, school board, and the directing or governing body of any political entity, subdivision, branch or unit of the Commonwealth or of any commission or public authority or body corporate created by or under an act of the General Assembly specifying the power or powers, privileges or authority capable of exercise by the commission or public authority or body corporate, as distinguished from §§15.2-1300, 15.2-1303 of the Code of Virginia, or similar statutes.

"Local officer" means the treasurer, registrar, commissioner of revenue, attorney for the Commonwealth, clerk of a circuit court, sheriff, or constable of any county or city or deputies or employees of any of the preceding local officers.

"Local retiree" means a former local employee who has met the terms and conditions for early, normal or late retirement from a local employer.

"Open enrollment" means the period during which an employee may elect to commence, to waive or to change membership or plans offered pursuant to the health benefits program.

"Part-time employee," as defined by each local employer, means an employee working less than full time whom a local employer has determined to be eligible to participate in

the program. The conditions of participation for these employees shall be decided by the local employer in a nondiscriminatory manner.

"Participant" means any person actively enrolled and covered by the health benefits program.

"Plan administrator" means the department.

"Preferred provider organization" or "PPO" means an entity through which a group of health care providers, such as doctors, hospitals and others, agree to provide specific medical and hospital care and some related services at a negotiated price.

"Preexisting condition" means a condition which, in the opinion of the plan's medical advisors, displayed signs or symptoms before the participant's effective date of coverage. These signs or symptoms must be ones of which the participant was aware or should reasonably have been aware. The condition is considered preexisting whether or not the participant was seen or treated for the condition. It is also considered preexisting whether or not the signs and symptoms of the condition were correctly diagnosed.

"Primary coverage" means the health plan which will provide benefits first. It does not matter whether or not a claim has been filed for benefits with the primary health plan.

"Retiree" means any person who meets the definition of either a state retiree or a local retiree.

"Secondary coverage" means the health plan under which the benefits may be reduced to prevent duplicate or overlapping coverage.

"Self-funded arrangement" means a facility through which the plan sponsor agrees to assume the risk associated with the type of benefit provided without using an insurance company.

"Single membership" means coverage of the employee only under the health benefits program.

"State" means the Commonwealth of Virginia.

"State agency" means a court, department, institution, office, board, council, or other unit of state government located in the legislative, judicial or executive departments or group of independent agencies, as shown in the Appropriation Act, and which is designated in the Appropriation Act by title and a three-digit agency code.

"State employee" means any person who is regularly employed full time on a salaried basis, whose tenure is not restricted as to temporary or provisional appointment, in the service of, and whose compensation is payable, no more often than biweekly, in whole or in part, by the Commonwealth or any department, institution, or agency thereof. "State employee" shall include the Governor, Lieutenant Governor, Attorney General, and members of the General Assembly. It includes "judge" as defined in §51.1-301 of the Code of Virginia and judges, clerks and deputy clerks of regional juvenile and domestic

relations, county juvenile and domestic relations, and district courts of the Commonwealth.

"State retiree" means a former state employee who has met the terms and conditions for early, normal or late retirement from the Commonwealth.

"Teacher" means any employee of a county, city, or other local public school board.

1VAC55-20-30. Designee and delegations of authority.

Pursuant to §2.2-2818 of the Code of Virginia, the Department of Human Resource Management shall establish a health benefits program (the "program"), subject to the approval of the Governor, for providing accident or health benefit protection, including but not limited to chiropractic treatment, hospitalization, medical, surgical and major medical coverage for state employees and the employees of participating local employers.

The Director of the Department of Human Resource Management hereby delegates to the Director of the Office of Health Benefits the authority to:

1. Propose, design, and administer one or more accident or health plans, or both. All such approved plans will, in the aggregate, constitute the health benefits program. Any plan or plans proposed by the Office of Health Benefits shall be subject to the approval of the Director of the Department of Human Resource Management.

2. Propose regulations at any time for the purpose of the implementation, communication, funding, and administration of the health benefits program.

3. Enter into one or more contracts for the purpose of implementing, communicating, funding or administering the health benefits program. To this end, but not exclusively, such contract or contracts may be for the underwriting, the funding, and administration, including claims processing and claims adjudication, of the program. Such contracts may be for the legal, accounting and actuarial services as well as communication, statistical analysis and any other item that may be needed to effectively review and maintain the health benefits program.

4. Evaluate the effectiveness of the health benefits program or any plan which may constitute a component part, as it might relate to the objectives of such program or such component plan and make recommendations regarding the effectiveness of such program or plan in meeting such stated objectives.

1VAC55-20-40. State advisory council.

In the administration of the health benefits program or any component plan or plans comprising such program, the department shall take into consideration the recommendations of the state human resource advisory council (the "council" or "advisory council"). The council is created pursuant to §2.2-2675 of the Code of Virginia and operated in accordance therewith. Such advisory council will serve to advise the Secretary of Administration on among other things, issues and concerns of active and retired employees of the Commonwealth who are participating

in the health benefits program, such as the type and amount of benefits provided by the program, the cost to employees to participate in the program and ways to effectively control claims experience. The department shall consider the findings and recommendations of the council in its decision-making process. Further, the department may request the council's guidance on other issues of concern to the department.

1VAC55-20-50. [Repealed]

1VAC55-20-60. Types of plans.

A The administration and underwriting of the plans shall be at the discretion of the department and may include but not be limited to self-funded arrangements, insured arrangements, administrative services arrangements, health maintenance organizations, and preferred provider organizations. The department is authorized to exercise judgment and discretion in the establishment, procurement and implementation of all underwriting and other services necessary for the establishment, maintenance, and administration of such plans and will be deemed to do so in good faith.

B. The department, as it deems necessary or prudent, may contract for outside services, including but not limited to actuarial, consulting, and legal counsel. The department may contract such services on an individual basis or in conjunction with other services.

1VAC55-20-70. Procurement.

The department shall comply with the Virginia Public Procurement Act, Chapter 43 (§2.2-4300 et seq.) of Title 2.2 of the Code of Virginia, as it may relate to any services to which such Act shall apply.

In an effort to stabilize the administration and maintenance of the health benefits program, the department may contract for services applicable to such program for a period of time not exceeding 10 years, with the department reserving the right, in its sole discretion, to cancel such contracts annually upon 90 days written notice to the contractor.

1VAC55-20-80. Plan assets.

A. The assets of the health benefits program, together with all appropriations, contributions and other payments, shall be deposited in the employee health insurance fund(s) (the "health insurance fund(s)") from which payments for claims, premiums or other contributions, cost containment and administrative expenses shall be withdrawn from time to time.

B. The health insurance fund for state employees shall be maintained separate and apart from the health insurance fund for retirees of the state eligible for Medicare and from the health insurance fund for local employees. All such funds shall be maintained for the exclusive benefit of the employees participating currently in the respective health insurance plans.

C. The department may designate with the approval of the Department of the Treasury one or more insurance companies, banks or any such similar institution as a direct recipient

of premiums or other contributions for part or all coverage under the health benefits program from local and state employers.

D. The assets of the fund shall be held for the sole benefit of the employee health insurance fund and to that end, employees participating in the health benefits program.

Any interest on unused balances in the fund shall revert back to the credit of the fund. The State Treasurer shall charge reasonable fees to recover the actual costs of investing the assets held in the fund.

1VAC55-20-90. Appeals.

A. The director of the department shall be the final arbiter of any disputes arising under this chapter. The director may not redelegate this authority other than to an independent hearing officer except as provided under subsection C of this section.

All disputes arising under this chapter shall be submitted to the department, which shall have the responsibility for interpreting and administering this chapter. All disputes shall be made in writing in such manner as may be reasonably required by the department and shall set forth the facts which the applicant believes to be sufficient to entitlement to relief hereunder. The department may adopt forms for such submissions in which case all appeals shall be filed on such forms.

B. Appeals not filed within the time frames established herein shall be denied.

Requests for review of procurements under the provisions of the VPPA shall be filed within 10 days of the department's notice of intent to award a contract.

Requests for relief from local employers or state agencies with respect to any action of the department other than a procurement shall be filed within 30 days of the action grieving the applicant. Requests for relief from state or local employees with respect to any action of the department other than a procurement shall be filed within 60 days of the action grieving the employee.

C. Upon receipt by the department for a request for review under this section, it shall determine all facts which are necessary to establish the right of an applicant for relief. The department shall approve, deny or investigate any and all disputes arising hereunder. Upon request, the department will afford the applicant the right of a hearing with respect to any finding of fact or determination related to any claim under this section. In the event of an adverse decision by the department, the applicant shall be notified of such decision as hereinafter provided. Reviews for treatment authorizations or medical claims that have been denied will be sent to an impartial health entity. The impartial health entity shall examine the final denial of claims or treatment authorizations to determine whether the decision is objective, clinically valid, and compatible with established principles of health care. The decision of the impartial health entity shall (i) be in writing, (ii) contain findings of fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if consistent with law and policy.

D. The applicant shall be notified in writing of any adverse decision with respect to his claim within 90 days after its submission. The notice shall be written in a manner calculated to be understood by the applicant and shall include:

1. The specific reason or reasons for the denial;

2. Specific references to law, this chapter, contracts awarded pursuant to this chapter, or the Health Insurance Manual/Local Administrative Manual and related instructions on which the denial is based;

3. A description of any additional material or information necessary to the applicant to perfect the claim and an explanation why such material or information is necessary; and

4. An explanation of the review process.

If special circumstances require an extension of time for processing an initial application, the department shall furnish written notice of the extension and the reason therefore to the applicant before the end of the initial 90-day period. In no event shall such extension exceed 90 days.

E. Standards, credentials, and qualifications of the impartial health entity.

1. In order to qualify to perform either standard or expedited external reviews pursuant to this chapter or the Code of Virginia, an impartial health entity shall have and maintain written policies and procedures that govern all aspects of the standard and expedited external review processes that include, at a minimum, a quality assurance mechanism in place that ensures that:

a. External reviews are conducted within the specified time frames and required notices are provided in a timely manner;

b. Qualified and impartial clinical peer reviewers are selected to conduct external reviews on behalf of the impartial health entity and reviewers are suitably matched to specific cases; and

c. The confidentiality of medical records is maintained in accordance with the confidentiality and disclosure laws of the Commonwealth and/or the Health Insurance Portability and Accountability Act.

2. All clinical peer reviewers assigned by an impartial health entity to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:

a. Are expert in the treatment of the covered person's medical condition that is the subject of the external review;

b. Are knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating

patients with the same or similar medical conditions as the covered person's;

c. Hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

d. Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental or professional competence or moral character.

3. An impartial health entity shall not be affiliated with or a subsidiary of nor be owned or controlled by a health plan, a trade association of health plans, or a professional association of health care providers.

4. In determining whether an independent review organization or a clinical peer reviewer of the impartial health entity has a material, professional, familial or financial conflict of interest, the director may take into consideration situations where the characteristics of that relationship or connection are such that they are not materially sufficient to disqualify the impartial health entity or the clinical peer reviewer from conducting the external review.

1VAC55-20-100. No presumption of right.

These regulations and the health benefits program herein established shall not be deemed to constitute a contract of employment between any participating employer and any participant. No participant in the program shall acquire any right to be retained in the employer's employ by virtue of the program, nor, upon the participant's dismissal or voluntary termination of employment, shall the participant have any interest in any assets of the program other than as may be specifically provided herein.

Furthermore, these regulations and the health benefits program herein established shall in no event confer upon any participant any rights, duties or responsibilities other than those granted herein. The Commonwealth of Virginia specifically reserves the right to amend, modify or terminate, inclusive of eligibility, coverage and contributions provisions, the health benefits program or any plan or plans comprising all or part of the program, as they may relate to any active or retired participant.

1VAC55-20-110. Authority to withhold revenues.

In the event of default by any employer participating in the health insurance program authorized by §2.2-1204 of the Code of Virginia in the remittance of premiums or other fees and costs of the program, the State Comptroller is hereby authorized to pay such premiums and costs and to recover such payments from any funds appropriated and payable by the Commonwealth to the employer for any purpose. The State Comptroller shall make such payments, and recover an equivalent amount if possible, from an employer's appropriated funds upon receipt of notice from the director of the department that such payments are due and unpaid from the employer.

1VAC55-20-120. [Repealed]

1VAC55-20-130. Develop health benefits program.

A. The department shall develop a health benefits program which shall be flexible in its form and content so as to accommodate a structure which permits the creation of multiple accident and health plans. The department, however, may offer a single health insurance plan if it determines that that is the most effective use of plan resources. The department has full authority to make changes in plan terms including, but not limited to, benefits and contributions, or to change underwriters and administrators as it deems appropriate.

B. The department shall supplement these regulations by providing administrative guidance through the Health Insurance Manual, Local Administrative Manual, Flexible Benefits Administrative Manual, memoranda, and other communications.

1VAC55-20-140. Underwriting.

At the department's discretion, the program may either be created and maintained on a self-funded basis or procured from an insurance company licensed to do business in the Commonwealth of Virginia, or a combination of both. In addition, the department is authorized to contract with any third party providers for any and all services which may be necessary to design, administer, communicate or fund the health benefits program.

1VAC55-20-150. Employer application.

The department shall develop a form on which local employers may apply for participation in the health benefits program and make available such form to local employers joining such program. The department will advise local employers on questions pertaining to the application. Among other items the department may deem necessary, the application may include:

1. Information regarding the political subdivision such as the governing body, individuals or offices responsible to provide, receive and remit information to the department and the method by which information can or will be transmitted.

2. Information regarding the total number of employees and those employees currently covered, those who will immediately become eligible, and those whose participation is anticipated. This information can include but is not limited to demographic data such as the age and sex of employees, geographic location of residence and employment, dependent status, and information concerning employment responsibilities.

3. Information regarding past premiums, claims and enrollment experience, contribution history, financial arrangements with prior underwriters and the types of plans or benefits provided being offered within the five years prior to making the application.

1VAC55-20-160. Establishing contribution rates and accounting for contributions and claims.

A. The department shall establish one or more pools for establishing contribution rates and for accounting for claims and contributions for state employees and participating local employers. The plan for local employers shall be rated separately from the plan established for state employees. There are hereby authorized pools based on geographic and demographic characteristics and employment relationships. Such pools may include but shall not be limited to:

1. Active state employees, including retirees under age 65 and not eligible for Medicare;

2. Active local employees (excluding separately rated employees of public school systems);

3. Active employees of public school systems;

4. Retired state employees over age 65 and retired state employees eligible for Medicare;

5. Retired local employees (excluding separately rated employees of public school systems);

6. Retired employees of public school systems; and

7. Active employees whose employer does not sponsor a health insurance plan.

Participating employers shall make applicable contributions to the employee health insurance fund.

B. Such contributions may take into account the characteristics of the group, such as the demographics of employees, inclusive of age, sex and dependent status of the employees of an employer; the geographic location of the employer or employees; claims experience of the employer; and the pool of the employers (for example, see subdivisions 1 through 6 of 1VAC55-20-160 A). Additionally, any such contributions may further be determined by spreading large losses, as determined by the department, across pools. Further, the department reserves the right to recognize, in its sole discretion, the claims experience of groups of sufficient size, regardless of their pool, where future claim levels can be predicted with an acceptable degree of credibility. The application of this rule by the department shall be exercised in a uniform and consistent manner.

C. The contribution rate in the aggregate will be composed of two factors; first, the current contribution and second, the amortization of experience adjustments. The current contributions will reflect the anticipated incurred claims and administrative expenses for the period; an experience adjustment will reflect gains and losses determined in accordance with an actuarial estimate. An experience adjustment will be part of the contributions for the succeeding year; however, the department may authorize the amortization of the experience adjustment for a period not to exceed three years.

D. The department will notify a terminating local employer of any adverse experience adjustment within six-calendar months of the time the local employer terminates participation in the program. Further the department reserves the right to modify the

amount of the experience adjustment applicable to a terminating local employer for a period not to exceed 12 months from the end of the plan year in which such termination occurred. The experience adjustment shall be payable by the local employer in 12 equal monthly installments beginning 30 days after the date of notification by the department. In the event that a terminating local employer requests in writing an extension beyond a period of 12 months, the department may approve an extension up to 36 months provided the local employer agrees to pay interest at the statutory rate on any extended payments.

1VAC55-20-170. Information to local employers.

The department will provide guidance and support to local administrators in the adoption, implementation and administration of the health benefits program.

The department shall furnish local employers with any and all information necessary for any reports the local employer is required to file with any federal or state agency as well as any information necessary for meeting the qualification or nondiscrimination rules under the Internal Revenue Code which may be applicable to such plans.

1VAC55-20-180. Information to local employees.

The department shall inform local employees when their coverage terminates by reason of nonpayment of premiums for the local employee group by the local employer. The form of the first notice shall be a notice in a newspaper of general circulation in the locality of the local employer. Such notice shall be prospective with respect to the date of termination. The form of the second notice shall be a letter to each contract holder at the contract holder's address of record.

1VAC55-20-190. Confidentiality.

The department will not disclose identifiable individual health data without the consent of the individual being provided coverage. The department may rely on the representations of any parent or guardian regarding such parent's or guardian's consent to the release of information regarding a child of such parent or any other person to which such guardianship shall apply. Data may be compiled into statistical reports provided that the identity of individual persons is not ascertainable by the reader or disclosed by the department.

1VAC55-20-200. Reports.

The department, on an annual basis, shall provide a report to the General Assembly. Such report shall discuss the overall objectives of the health benefits program, including enrollment, income and expense, participation by local employers and additional matters of general concern.

1VAC55-20-210. Oversight.

The department has the responsibility and authority to maintain the health benefits program and take any action it deems necessary to maintain the financial and administrative integrity of the program.

A. The department shall review local administration, including state agency administration of the health benefits program to determine compliance with this chapter, law, and administrative directives. Deficiencies shall be reported to the governing body or agency administrator, who shall take prompt action to remedy the noted deficiencies. To this end, the department shall provide guidance to responsible parties regarding their duties and responsibilities in the administration of the program. Failure to correct noted deficiencies may result in the unilateral termination of participation (in the case of a local employer) in the health benefits program, or a revocation of the agency's administrative responsibility for the health benefits program (in the case of a state agency) and the imposition of a special employer contribution on the state agency to pay for the cost of direct administration of the program by the department. The cost of direct administration shall be determined by the department.

B. The department may exclude from coverage any person who is not eligible for coverage notwithstanding the participation of the state agency or local employer in the health benefits program or the payment of contributions or the previous payment of claims on behalf of such person.

If a person is determined to be ineligible for coverage, claims paid by the program during this period of ineligibility shall be recouped by the program from providers of care and from the ineligible employee to the extent practicable as determined by the department.

Employer contributions on behalf of ineligible persons shall not be returned to the participating employer in as much as the employer agrees by participating in the health benefits program that the amount of such contributions constitute liquidated damages for enrolling ineligible employees and/or their dependents. Employee contributions will not be refunded, and the membership level and contributions rate will be maintained, at the level they had been prior to the removal of the ineligible dependent, until such time as the employee makes a membership change due to a consistent qualifying midyear event, or during open enrollment.

C. The department may exclude from coverage for a period of three years any employee (and dependent) who is found by the department to have enrolled in the health benefits program through fraud, deceit, or misrepresentation of a dependent who is not eligible for the program. A signed enrollment form or equivalent enrollment action shall be deemed prima facie evidence of misrepresentation.

D. The department may refuse, notwithstanding any agreement or assignment from a participant or third party, to make a payment on behalf of a participant for covered services to a provider of care who has been determined by the department to be abusing or defrauding the program. A pattern of billing for services not rendered, misrepresenting the complexity or length of the procedures or services actually rendered, or similar abuses shall compel the department to make such a determination. For the purposes of this section, a "pattern" constitutes a number of instances over a period of at least three months which are so similar as to suggest that the abuse is present in 5.0% or more of the services or procedures billed.

1VAC55-20-220. Eligible employers.

Pursuant to §2.1-20.1:02 of the Code of Virginia, local employers may, by making proper application and complying with this chapter, participate in the health benefits program.

1VAC55-20-230. Entrance into the health benefits program.

A. Any local employer desiring to participate in the health benefits program shall complete an employer application provided by the department and execute an adoption agreement acknowledging the rights, duties and responsibilities of the department and the local employer.

As a condition of participation, the department may require the local employer to complete the application in its entirety and deliver it to the department no less than 120 days prior to the effective date of coverage under the health benefits program. The application shall include the designation of a local administrator and include a list of other individuals whose responsibilities may be such that the department may have cause to contact them.

The application of a local employer may be withdrawn without penalty any time within the first 30 days after the department's delivery of rates to the employer. A 15-day extension will be available upon written request by the employer. Thereafter, the department may levy a processing charge not to exceed $500 to cover the cost of processing the application.

B. Except in unusual circumstances to be determined by the department, the completion of any waiting periods will not be required of employees of local employers joining the program at the time of a local employer's initial participation.

C. Local employers may include in the program their active employees, or their active employees and their retirees. Local employers may not elect to cover only retirees. If the local employer wishes to provide benefits to their Medicare-eligible retirees it must also provide coverage for non-Medicare retirees. The local employer's beneficiaries qualified under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or similar legislation may also participate in the program. Coverage will not be available to a new employee unless the employee is on the payroll a minimum of 16 calendar days.

1VAC55-20-240. Payment of contributions.

A. Contributions due. It is the sole responsibility of the local employer to remit local employer and local employee contributions to the department or its designee. The local employer is responsible for remitting such contributions for active, retired, and COBRA-participating employees. Health benefits program contributions are to be made monthly, in advance, and are due at the department on the first of each month. If the first day of the month falls on a weekend or holiday, the payment is due at the department on the first business day of the month.

B. Nonpayment of contributions. A 10-day grace period for the nonpayment of contributions is hereby provided. If the full and complete payment of contributions is not received by the 10th of the month, a notice will be sent to the local employer by the department or its designee. Additionally, there shall be imposed an interest penalty of 12% per annum of the outstanding balance unpaid as of the 10th.

In the event that payment is not received by the 20th of the month, the department shall place a notice of nonpayment of contributions in a newspaper of general circulation in the locality of the local employer notifying the employees of such local employer that

claims incurred after the end of the current month will not be paid until all outstanding contributions and interest have been paid.

Furthermore, the department reserves the right to collect from a local employer the greater of the monthly contribution or any amounts incurred for claims during a period of nonpayment as well as any other costs related thereto.

C. Nonpayment as breach. The nonpayment of contributions by a local employer shall constitute a breach of the adoption agreement and the local employer may be obligated to pay damages. In the event that the local employer terminates participation, such termination can only be prospective and the employer shall be obligated to pay the greater of past contributions or actual claims incurred during such period and any interest and damages that may be associated with such nonpayment.

D. Coverage and contribution period. Except as noted here, coverage elections including those made by new employees are made on a prospective basis, that is, effective the first of the month coinciding with or following the receipt of the election form. However, if an election form is received from a new employee on the first business day of the month, coverage for the employee will commence on the first day of that month, (see 1VAC55-20-370). Coverage elections made for newborns, adoption or placement for adoptions are effective the date the child is born, adopted or placed for adoption, so long as the employee makes the coverage election within 31 days of the event. Coverage terminations are effective the end of the month following receipt of an election notice, except for terminations that are required by the plan. Coverage terminations required by the plan are effective the end of the month that the event takes place. Examples of coverage terminations required by the plan are such things as a divorce, termination of employment or a dependent child losing eligibility.

Contributions shall always be for full calendar months. Local employees who terminate employment within a calendar month shall have coverage through the end of the month in which they terminate. In the event that a terminating local employee becomes covered under an accident or health plan of another employer prior to the end of the month in which the local employee terminates, this health benefits program shall be a secondary payor to the former local employee's new coverage.

1VAC55-20-250. Enrollment.

The local employer is responsible for providing local employees with enrollment forms for participation in the health benefits program. Such forms shall be provided to the local employer by the department or its designee. It is the responsibility of the local employer to provide information to local employees concerning the benefits offered in each of the plans comprising the health benefits program at such time and in such manner that it can be expected that the local employee can make an informed decision regarding the types of coverage that are being offered.

The local employer is responsible for ensuring that enrollment forms for participation made by local employees are fully completed on a timely basis, signed and certified. No later than 30 days prior to the effective date of coverage, the local employer shall forward the enrollment forms to the department or its designee, as may be appropriate. The department shall be responsible for notifying the local employer as to the location and manner of delivery of all such local employee enrollment forms. Further, the local employer shall be responsible for reporting any changes in

benefit coverage in a manner similar to the reporting of an initial application with the department having the ability to waive the 30-day notice requirement.

1VAC55-20-260. Minimum local employer contributions.

A. The department shall require, as a condition of local employer participation in the health benefits program, that a local employer pay a minimum portion of the plan contribution attributable to an active local employee's coverage. Contributions toward the cost of retiree coverage are permitted but not required. Unless otherwise specified in a local employer's adoption agreement, participating local employers shall contribute, at a minimum, 80% of the cost of single coverage, and 20% of the cost of dependent coverage as a condition of participation. In the event that an employer enrolls 75% or more of all eligible employees, the employer will not be required to contribute the above amounts towards the cost of dependent coverage.

B. Local employers allowing part-time employees to participate in the program must contribute a minimum of 50% of the amount they contribute toward active employee coverage (at all membership levels) on behalf of their participating part-time employees.

For purposes of this section, amounts contributed on behalf of an employee who has requested a reduction in salary pursuant to a plan qualified under §125 of the Internal Revenue Code (Tax Treatment of Cafeteria Plans) will not be counted as an employer contribution.

1VAC55-20-270. Selection of plans.

Local employers electing to participate in the health benefits program must, as a condition of participation, agree to offer exclusively one or more plans constituting such program. Notwithstanding the above, a local employer, with the approval of the department may offer another accident or health plan provided that such other plan does not duplicate the coverage offered by the health benefits program. Such permission shall not be unreasonably withheld.

Local employers participating in the health benefits program who desire to offer a health maintenance organization (HMO) must offer the HMOs included in the health benefits program and only those HMOs.

1VAC55-20-280. Commencement of local employer participation.

Local employers may join initially at any time upon the timely submission of an employer application, but, thereafter, renewals must be as of July 1 of each year. Local school boards may have an October 1 renewal, if they so elect. Initial participation by a local employer at any time other than on July 1 (October 1) may be for the short plan year ending on the June 30 (September 30) following initial participation.

There shall be no specified time for local employee enrollment coincident with the local employer's initial participation in the health benefits program provided the department or its designee shall have knowledge of the local employee elections at least 30 days prior to the effective date of coverage. Thereafter the open enrollment period for local employees shall take

place during the month of April or May of each year with the effective date of coverage then being July 1 of such year.

1VAC55-20-290. Reparticipation of local employers.

Local employers having withdrawn from the health benefits program may reenter the program only with the consent of the department, and only on the July 1 (October 1 for school boards) following the timely submission of an employer application. The July 1 (October 1) effective date may be waived for local employers who have been away from the program for more than three years. Employees of local employers seeking reparticipation may be required to serve a waiting period.

Department consent shall not be granted until all pending contributions, penalties and other assessments have been paid by a local employer and there is no outstanding litigation pending between the department and the local employer. A pending appeal will not prohibit a local employer from reparticipating in the health benefits program.

1VAC55-20-300. Ceasing participation in the health benefits program.

A local employer who desires to terminate participation in the health benefits program may do so at any time, as of the last day of any calendar month, with three months notice to the department. The local employer shall be obligated to pay any and all contributions otherwise required through the date of termination of participation and interest related thereto. Additionally, a terminating local employer shall be responsible for any adverse experience adjustment which may apply with respect to the year termination occurred and any prior year within which the terminating local employer participated in the program.

Upon the local employer's cessation of participation in the program, all of the local employers' participants, including retirees, dependents of retirees and COBRA beneficiaries will cease to be covered under the program.

1VAC55-20-310. Compliance.

The department shall oversee the local employers and state agencies and shall assist the employees thereof in the pursuit of all rights and benefits. The department shall hold the employee harmless for any errors made by local employers and state agencies. The cost of any such errors, where applicable, shall be borne by the local employer or state agency, and not the employee.

Nothing in this chapter shall affect the rights of any local employee to bring a cause of action against a local employer for action taken hereunder with respect to such local employer's willful disregard of this chapter. In the event a local employee brings a cause of action against the department due to a local employer's willful disregard for the requirements of this chapter, the local employer as a condition of initial participation in the program shall reimburse the department for any such settlement required by a court of law.

1VAC55-20-320. Eligible employees.

A. State employees.

1. Full-time salaried, classified employees and faculty as defined in 1VAC55-20-20 are eligible for membership in the health benefits program. A full-time salaried employee is one who is scheduled to work at least 32 hours per week or carries a faculty teaching load considered to be full time at his institution.

2. Certain full-time employees in auxiliary enterprises (such as food services, bookstores, laundry services, etc.) at the University of Virginia, Virginia Military Institute and the College of William and Mary as well as other state institutions of higher learning are also considered state employees even though they do not receive a salaried state paycheck. The Athletic Department of Virginia Polytechnic Institute and State University is an example of a local auxiliary whose members are eligible for the program.

3. Certain full-time employees of the Medical College of Virginia Hospital Authority are eligible for the program as long as they are on the authority's payroll and were enrolled in the program on November 1, 1996. They may have payroll deductions for health benefits premiums even if they rotate to the Veterans' Administration Hospital or other acute care facility.

4. Other employees identified in the Code of Virginia as eligible for the program.

5. Classified positions include employees who are fully covered by the Virginia Personnel Act, employees excluded from the Virginia Personnel Act by subdivision 16 of §2.2-2905 of the Code of Virginia, and employees on a restricted appointment. A restricted appointment is a classified appointment to a position that is funded at least 10% from gifts, grants, donations, or other sources that are not identifiable as continuing in nature. An employee on a restricted appointment must receive a state paycheck in order to be eligible.

B. Local employees.

1. Full-time employees of participating local employers are eligible to participate in the program. A full-time employee is one who meets the definition set forth by the local employer in the employer application.

2. Part-time employees of local employers may participate in the plan if the local employer elects and the election does not discriminate among part-time employees. In order for the local employer to cover part-time employees, the local employer must provide to the department a definition of what constitutes a part-time employee.

The department reserves the right to establish a separate plan for part-time employees.

C. Unavailability of employer-sponsored coverage.

1. Employees, officers, and teachers without access to employer-sponsored health care coverage may participate in the plan. The employers of such employees, officers, and teachers must apply for participation and certify that other employer-sponsored health care coverage is not available. The employers shall collect contributions from such individuals and timely remit them to the

department or its designee, act as a channel of communication with the covered employee and otherwise assist the department as may be necessary. The employer shall act as fiduciary with respect to such contributions and shall be responsible for any interest or other charges imposed by the department in accordance with these regulations.

2. Local employees living outside the service area of the plan offered by their local employer shall not be considered as local employees whose local employers do not offer a health benefits plan. For example, a local employee who lives in North Carolina and works in Virginia may live outside the service area of the HMO offered by his employer; however, he may not join the program individually.

3. Employer sponsorship of a health benefits plan will be broadly construed. For example, an employer will be deemed to sponsor health care coverage for purposes of this section and 1VAC55-20-260 if it utilizes §125 of the Internal Revenue Code or any similar provision to allow employees, officers, or teachers to contribute their portion of the health care contribution on a pretax basis.

4. Individual employees and dependents who are eligible to join the program under the provisions of this subsection must meet all of the eligibility requirements pertaining to state employees except the identity of the employer.

D. Retirees.

1. Retirees are not eligible to enroll in the state retiree health benefits group outside of the opportunities provided in this section.

2. Retirees are eligible for membership in the state retiree group if a completed enrollment form is received within 31 days of separation for retirement. Retirees who remain in the health benefits group through a spouse's state employee membership may enroll in the retiree group at one of three later times: (i) future open enrollment, (ii) within 31 days of a qualifying mid-year event, or (iii) within 31 days of being removed from the active state employee spouse's membership.

3. Membership in the retiree group may be provided to an employee's spouse or dependents who were covered in the active employee group at the time of the employee's death in service.

4. Retirees who have attained the age of 65 or are otherwise covered or eligible for Medicare may enroll in certain plans as determined by the department provided that they apply for such coverage within 31 days of their separation from active service for retirement. Medicare will be the primary payor and the program shall serve as a supplement to Medicare's coverage.

5. Retirees who are ineligible for Medicare must apply for coverage within 31 days of their separation from active service for retirement. In order to receive coverage, the individual must meet the retirement requirements of his employer and receive an immediate annuity.

6. Local employers may offer retiree coverage at their option.

E. Dependents.

1. The following family members may be covered if the employee elects:

a. The employee's spouse.

b. The employee's unmarried natural or legally adopted children.

c. Unmarried stepchildren living with the employee in a parent-child relationship and dependent on the employee for federal tax purposes.

d. Adult incapacitated children as long as the child was covered by the plan and the incapacitation existed prior to the termination of coverage due to the child attaining the limiting age.

e. Adult incapacitated children of new employees, provided that:

(1) The enrollment form is submitted within 31 days of hire;

(2) The child has been covered continuously by group employer coverage since the disability first occurred; and

(3) The disability commenced prior to the child attaining the limiting age of the plan.

The enrollment form must be accompanied by a letter from a physician explaining the nature of the incapacitation, date of onset and certifying that the dependent is not capable of self-support. This extension of coverage must be approved by the plan in which the employee is enrolled.

f. Other children on an exception basis. Generally, an exception will not be granted unless:

(1) A court orders the eligible employee to assume permanent custody of the child; and

(2) Both of the child's natural parents are deceased, missing, or incarcerated or a court order has found the parents incapable of caring for the child.

Local employers and state agencies do not have the authority to grant exceptions. If the circumstances appear to meet the criteria, the facts of the case must be sent in writing to the department for a determination. Minor children who are adopted, regardless of relationship to the employee, enjoy the same benefits as natural children. Natural or adopted children who are otherwise eligible for coverage may be covered by the employee whether or not they live with the employee.

Children of the spouse of an eligible employee may not be covered as a dependent in the health benefits program unless they live with the employee and meet the criteria for family membership, as given in previous paragraphs.

A child who is self-supporting for federal income tax purposes is ineligible to be covered under the employee's family membership. A child who is otherwise eligible to be covered by family membership may be covered until such time as he becomes self-supporting.

Coverage for a dependent child stops at the end of the month in which the child marries.

g. Special rules.

(1) There are certain categories of persons who may not be covered as dependents under the program. These include: dependent siblings, grandchildren, nieces, nephews, and most other children except where the criteria for "other children" are satisfied (see 1VAC55-20-320 E 1 f). Parents, grandparents, aunts and uncles are not eligible for coverage regardless of dependency status.

(2) Under the health benefits program, eligible children may be covered to the end of the year in which they turn age 23 regardless of student status, if the child lives at home, is not married and is not self-supporting. In the case of natural or adopted children, living at home may mean living with the other parent if the employee is divorced. Also, a child who is away at school may be covered.

Children may be covered regardless of the age if incapable of self-support because of a severe physical or mental incapacitation, which was diagnosed while coverage was in force. An enrollment form for continued coverage for a disabled child is required within 31 days prior to the child's age attainment (above) to maintain coverage (see 1VAC55-20-330).

1VAC55-20-330. Enrollment form or enrollment action.

A. No coverage is available unless an employee files an enrollment form or takes an equivalent enrollment action. No changes in coverage are effective unless an employee files an enrollment form or takes an equivalent enrollment action. Employees alone are responsible for knowing when an enrollment action is required, for taking the action, and for certifying that the information conveyed is complete and true.

B. The employer is responsible for checking that the employee fills in the form completely and accurately. The employer will certify each enrollment form in the space provided on the form.

C. The effective date of coverage shall be determined from the date the enrollment form is stamped as received by a designee of the department or the date of the equivalent enrollment action. This is generally the first of the month following receipt.

Except as noted here, coverage elections including those made by new employees are made on a prospective basis, that is, effective the first of the month following the receipt of the election form or enrollment action. However, if the receipt of the form or the date of the enrollment action is the first of the month, then the effective date will be the first of the month. Additionally, if an election form or enrollment action is received from a new employee on the first business day of the month, coverage for the new employee will commence on the first day of that month (see 1VAC55-20-370). Coverage elections made on account of a newborn, adoption or placement for adoption are effective the date the child is born, adopted or placed for adoption, as long as the employee makes the coverage election within 31 days of the event. Coverage terminations are effective the end of the month following receipt of an election notice, except for terminations that are required by the plan. Coverage terminations required by the plan are effective the end of the month that the event takes place. Examples of coverage terminations required by the plan are such things as a divorce, termination of employment or a dependent child losing eligibility.

1VAC55-20-340. Payment of contributions.

A. Active employees shall pay their portion, if any, of contributions through payroll deduction.

B. State retirees will have their contributions deducted from VRS or other retirement system. If the retirement payment is not sufficient to pay the entire contribution, they may pay their contributions directly to the department's designee. There may be an administrative fee for direct payment. Such fee may be waived by the department if payment is made monthly by bank draft.

A credit toward the cost of coverage is made by the Commonwealth on behalf of retired state employees as provided in §51.1-1400 of the Code of Virginia.

C. Retired employees of local employers shall pay contributions by either of two methods. The retired employee may authorize contributions to be deducted from the retiree's pension payment, whether it be through the VRS or otherwise. Alternatively, if the employer so provides, the retiree may pay his contribution to the employer who shall be responsible for remitting the contributions to the department or its designee. In either case the employer is responsible for collecting and submitting the premium to the plan at the time that the active premium is submitted.

1VAC55-20-350. Membership.

A. Type of membership. Participants have a choice of three types of membership under the program:

1. Single (employee only). If a participant chooses employee only membership, the health benefits program does not cover the employee's dependents (spouse or children). A woman with single membership under the program does have maternity coverage. However, the newborn child is covered only for routine hospital nursery care, unless the mother changes to dual or family membership within 31 days of the date of birth.

2. Dual (employee and one eligible dependent).

3. Family membership (employee and two or more eligible dependents).

B. Changing type of membership.

1. Employees may change membership subject to 1VAC55-20-370.

a. During open enrollment.

b. Within 31 days of a qualifying mid-year event. Any such change in membership must be on account of and consistent with the event.

c. Within 31 days of a cost and coverage change, as acknowledged by the department.

2. All changes in membership must be made on a prospective basis except for the birth, adoption or placement for adoption of a child.

3. If the change is from single to dual or family membership or vice versa because of a qualifying mid-year event, the employee must certify in the enrollment action the type of event and the date of the event.

1VAC55-20-360. Choice of plans.

A. During the annual open enrollment period, state employees and non-Medicare retirees eligible to participate in the health benefits program have a choice of enrolling in any plan offered by their employer, which may often include an alternative health benefits plan offered by the department. To be eligible for membership in the health benefits program, the employee or retiree must live or work within the service area of the particular plan.

B. Employees of participating local employers have a choice of enrolling in the plans offered by their respective employers. Local employers have the option of requiring that employees live within the service area of the plan the employee chooses to join or of allowing employees to join a plan if they live or work in the service area.

C. An enrollment action will not be accepted outside of open enrollment except for an employee who experiences a qualifying mid-year event.

D. The employer's contribution toward coverage, if any, shall be determined by the employer except with respect to the minimum contribution rate applicable to local employers.

1VAC55-20-370. Effective date of coverage.

A. General. Coverage and changes in coverage or membership are generally prospective, effective on the first day of the month following the month in which the enrollment action is received by the department's designee.

B. Date coverage begins. Coverage begins on the first day of the first full month of employment following the receipt of the employee's enrollment action. Employees who begin work on the first working day of the month are considered employed effective the first of the month. Thus, if an employee submits the completed enrollment action on or prior to the first working day of the month, coverage will be effective the first of the month in which employment commenced.

C. Exceptions. With prior approval from the department, coverage may be allowed to commence on an earlier date in limited circumstances when prior coverage is unavailable; for example, a new employee who has moved out of the service area of an HMO.

1VAC55-20-380. Leaves of absence.

Note: This section addresses various aspects of employee leave and may or may not be applicable to a local employer.

A. Leave of absence with full pay. As long as an employee is still receiving full pay, health benefits coverage continues with the employer making its contribution. Nothing special must be done to maintain coverage.

Local employers are not required to contribute toward coverage for any part-time employee granted any type of leave of absence.

B. Virginia Sickness and Disability Program, Long-Term Disability (VSDP-LTD)

1. Coverage with the employer contribution continues to the end of the month in which the LTD benefits begin, unless benefits begin on the first day of the month, in which case the employer contribution will end on the last day of the preceding month. Thereafter, employees may continue coverage by paying the entire cost of the coverage.

2. Employees receiving LTD benefits may enroll in the State Retiree Health Benefits Program upon service retirement regardless of whether they have maintained health coverage in the state program provided that the individuals have been continuously covered and have had no break in long-term disability benefits prior to service retirement. The LTD participant has 31 days from the date of retirement to enroll in the State Retiree Health Benefits Program. Coverage in the retiree group begins on the first day of the first full month of retirement.

C. Educational leave—full or partial pay. An official educational leave is a leave for educational reasons with partial or full pay maintained for the leave, not for work rendered. It is possible to maintain health coverage on an educational leave even when less than full pay is given provided that at least half pay is given. Coverage may continue for the duration of the leave up to 24 months.

D. Leave of absence without pay.

1. Coverage with the employer contribution continues to the end of the month in which the leave without pay begins provided the first day of the leave is after the first work day of the month. If the person returns from leave the following month and works at least half of the workdays in the month, coverage will be continuous. If the leave without pay begins on or before the first work day of the month, coverage and the employer contribution ceases on the last calendar day of the previous month.

2. Employees who do not want to continue coverage will be asked to sign a waiver.

E. Changing coverage while on leave. Coverage changes may be made while on leave in the same manner that changes may be made while actively employed. The same procedures and rules apply.

An employee enrolled in an alternative health benefits plan who moves out of the plan's service area while on a leave of absence may change to another plan offered by the department in his new location by taking an enrollment action within 31 days of the date of the move.

F. Returning from leave without pay.

1. Employees who have maintained coverage while on leave without pay. If the employee has maintained coverage while on leave, the employee's coverage in the health benefits program (with the employer making its contribution) will begin on the first of the month following the date the employee returns to full-time employment. However, if the return to work falls on the first day of the month then the employer contributions may begin immediately. It is not necessary for the employee to take a new enrollment action.

   Employees may change from single to dual or family membership within 31 days of returning from leave without pay if the employee dropped dual or family membership during the leave or if there was a qualifying mid-year event during the leave. A new enrollment action must be taken. In the case of a qualifying mid-year event, the effective date would follow the rule on initiating dual or family membership at the time of the particular qualifying mid-year event.

2. Employees who have not maintained coverage while on leave will be treated in the same manner as new employees, unless they have exercised their rights under the Family Medical Leave Act. If these rights are exercised, they will have all rights that are required by law.

   a. It shall be necessary to take a new enrollment action to receive coverage. The enrollment action shall indicate the date the employee returned to work as the date that the employee's continuous full-time employment commenced.

   b. The employee has a choice of type of membership and plan.

c. The usual deadlines for filing apply. Coverage begins according to the rules and procedures for new employees.

3. Employees returning from military leave for active service. Employees returning from military leave of 30 days or more have the same choice of coverage as a new employee. If the employee returning from a military leave applies for coverage within 31 days of discharge, the coverage will begin on either the first day of the month of discharge or the first of the following month, whichever is necessary to effect continuous coverage.

4. Taking a second leave without pay. If an employee returns from a leave without pay and is employed full-time on every scheduled work day for at least one full calendar month before taking another leave without pay, the second leave will be treated as a new leave.

If there is less than one calendar month of full-time employment between leaves without pay, the leaves will be treated as one, regardless of the types of leave. The length of time that coverage may be continued will depend on the current type of leave.

1VAC55-20-390. Termination of coverage.

A. Coverage ends at the end of the month in which an employee terminates the employment relationship, otherwise loses group eligibility, or on the last day of the month for which premiums are paid.

B. Coverage ends on the date of a participant's death. Coverage for family members continues until the end of the month following the month in which the participant died.

1. A surviving beneficiary may enroll in the state retiree group if:

a. The dependent is eligible for an annuity under the VRS death-in-service provision;

b. The employee had submitted a disability retirement application naming the dependent under the survivor option before his death and the employee died prior to achieving the retirement date; or

c. The death was job related.

To continue coverage, the family member must apply within 60 days of the date the coverage would otherwise end due to the death.

2. Survivors of deceased employees who are not eligible for an annuity from VRS can nonetheless be covered under the State Health Benefits Program if they had coverage at the time the employee died. To continue coverage, the family member must apply within 60 days of the employee's death.

C. In the event that an employee on leave without pay notifies the employer that he is terminating employment, coverage ends on the last day of the month in which the leave without pay ceases.

1VAC55-20-400. Termination of employment.

A. Coverage continues to the end of the month in which an employee terminates. Each terminating employee may elect continuation of coverage pursuant to Internal Revenue Code section 4980B and accompanying regulations.

B. Terminating employees may also have the option of converting to a non-group policy. The carrier will send the employee a letter offering non-group coverage. The employee will have 30 days after the date of the letter to reply in order for coverage to be continuous. All terminating employees will be given certificates of coverage as required by the Health Insurance Portability and Accountability Act.

1VAC55-20-410. Suspension and reinstatement.

A. General.

1. Coverage generally continues through the end of the month in which the suspension began. However, if the suspension was effective on or before the first work day of the month, there will be no coverage for that month unless the employee is reinstated in time to work half of the work days in the month. For example, if a suspension is effective on April 19, the employee will have coverage through the end of April. If the suspension is effective April 1, the employee will have no coverage in April. By the same token, if the suspension is effective April 2 and the employee's first workday in April is April 3, the employee will not have coverage in April. If the employee is reinstated in time to work half of the workdays in the month following the month in which the suspension began, there will be continuous coverage.

2. If the employee is suspended pending court action or pending an official investigation, the suspension may go beyond one pay period. In these cases, coverage will continue to the end of the month in which the suspension began. If the employee is reinstated in time to work half of the workdays of the month following the month in which the suspension began, there would be no break in coverage. Suspension beyond that period should be handled in the same way as a leave without pay with no employer contribution. The employee may remain in the group by paying monthly contributions to the employer in advance. Group coverage may continue until a court decision is issued or the official investigation is completed, or up to a period of 12 months, whichever is less.

3. If the employee is reinstated with back benefits, the employer should refund the employee the amount of the employer contribution during the period the employee paid the full premium. Single membership should be reinstated retroactive to the date the employee was removed from the group up to a limit of 60 days. Retroactive dual or family membership will be available up to a maximum period of 60 days. Appropriate contributions must be made to cover the retroactive period. Alternatively, the family membership may begin the first

full month of reinstatement if the employee applies within 31 days of reinstatement.

B. Termination and grievance reinstatement.

1. Employees who are terminated and file a grievance shall be treated as terminated employees and may elect extended coverage or nongroup coverage. In the event such an employee is reinstated with back pay, he will be given single membership retroactive up to 60 days. Retroactive dual or family membership will be available up to a maximum period of 60 days. Appropriate contributions must be made to cover the period.

2. If the employee is reinstated without full back pay, no retroactive coverage is available.

1VAC55-20-420. [Repealed]

1VAC55-20-430. Coordination of benefits.

A. Employees are required to notify the plan administrator that they or a covered dependent are enrolled under another plan. If a plan participant is eligible for coverage under two or more plans, the plans involved will share the responsibility for the participant's benefits according to these rules.

B. If the other health benefit plan contains a coordination of benefits provision establishing the substantially same order of benefit determination rules as the ones in this section, the following will apply in the order of priority listed:

1. The plan that lists the person receiving services as the enrollee, insured or policyholder, not as a dependent, will provide primary coverage. There is one exception. If the person is also entitled to Medicare, and as a result of federal law Medicare is (i) secondary to the plan covering the person as a dependent; and (ii) primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering the person as other than a dependent.

2. Primary coverage for an enrolled child will be the plan which lists the parent whose month and day of birth occurs earliest in the calendar year as an enrollee, insured, or policyholder, except in the following circumstances:

a. When the parents are separated or divorced, primary coverage will be the plan that covers the child as a dependent of the parent with custody. The plan of the husband or wife of a remarried parent with custody may provide primary coverage if the remarried parent with custody does not have a plan that covers the child.

b. Despite subdivision 2 a of this subsection, if there is a court order that requires one parent to provide hospital or medical/surgical coverage for the child, primary coverage will be that parent's plan. If the specific

terms of a court decree state that the parents will share joint custody and the court decree does not state that one of the parents is responsible for health care expenses of the child, then the rule set forth in the first sentence of subdivision 2 of this subsection, the birthday rule, will apply.

3. If subdivisions 1 and 2 of this subsection do not apply, primary coverage will be the plan that has covered the participant for the longest uninterrupted period of time. There are two exceptions to this rule:

   a. The benefits of the plan that covers the person as a working employee (or the employee's dependent) will be determined before those of the plan that covers the person as a laid-off or retired employee (or the employee's dependent).

   b. The benefits of the plan that covers the person as an employee (or the employee's dependent) will be determined before those of the plan that covers the person under a right of continuation pursuant to federal or state law.

C. If a plan does not have a coordination of benefits provision establishing substantially the same order of benefit determination rules as the ones in this section, that plan will be the primary coverage.

D. If, under the priority rules, the state plan is the primary coverage, participants will receive unreduced benefits for covered services to which they are entitled under this plan.

E. If the other plan is the primary coverage, the participant's benefits will be reduced so that the total benefit paid under this plan and the other plan will not exceed the benefits payable for covered services under this plan absent the other plan. In calculating benefits that would have been paid under this plan absent the other plan, any reduction in benefits for failure to receive a referral will not be considered. Benefits that would have been paid if the participant had filed a claim under the primary coverage will be counted and included as benefits provided. In a calendar year, benefits will be coordinated as claims are received.

F. When a health benefit plan provides benefits in the form of services, a reasonable cash value will be assigned to each covered service. This cash value will be considered a "benefit payment."

G. At the option of the plan administrator, payments may be made to anyone who paid for the coordinated services the participant received. These benefit payments by the administrator are ones that normally would have been made to the employee or on the employee's behalf to a facility or provider. The benefit payments made by the administrator will satisfy the obligation to provide benefits for covered services.

H. If the administrator provided primary coverage and discovers later that it should have provided secondary coverage, the administrator has the right to recover the excess payment from the employee or any other person or organization. If excess benefit payments are made on behalf of the employee, the employee must cooperate with the administrator in exercising its right of recovery.

I. Employees are obligated to supply the plan administrator all information needed to administer this coordination of benefits provision. This must be done before an employee is entitled to receive benefits under this plan. Further, the employees must agree that the administrator has the right to obtain or release information about covered services or benefits received. This right will be used only when working with another person or organization to settle payments for coordinated services. The employee's prior consent is not required.

1VAC55-20-440. Claims.

Claims must be filed no later than the end of the calendar year after the year in which the claim is incurred. Claims not filed in a timely fashion will not be considered.

1VAC55-20-450. Basic plan.

The department may provide self-funded plan(s) administered by a third party administrator including, but not limited to, an exclusive provider organization (EPO) and a point of service plan (POS). These plans are described in the employee handbooks, which are distributed to employees upon enrollment. The department shall denote a self-funded plan as the "basic plan," which is required by code to be available throughout the state and shall provide the basis for all employer contributions.

1VAC55-20-460. Alternative health benefit plans.

The department also offers several health maintenance organization and preferred provider organization plans which are available to participants residing in the service area of the HMO or PPO. A list of these plans is available upon request to the department.

Non-Medicare-eligible retirees have the same enrollment options as active employees.

Retirees must enroll in a plan within 31 days of separation for retirement. A separating employee who defers retirement will not be eligible to enroll in a retiree medical plan when the former employee seeks retirement benefits.

1VAC55-20-470. Benefits coverage.

A. Interpretations of covered services will be made in the following manner, listed in order of priority:

1. The contract documents, including the request for proposal;

2. Member handbooks or contract booklets;

3. The interpretation of the department;

4. The interpretation of the department's contractors.

B. The benefit provisions of the contract documents are contained in the contract booklets or member handbooks distributed to employees by their benefits administrators.

C. The benefits administrators have copies of the contract booklets and member handbooks for all plans offered by that employer. By appointment, any employee or citizen may inspect the entire contract or contracts at the offices of the department.

1VAC55-20-480. Department discretion.

The department reserves the right to change the plans offered and benefits provided there under at its sole discretion based upon market and department considerations.

III. SUMMARY OF BENEFITS:

STATEWIDE PLANS ADMINISTERED BY ANTHEM BLUE CROSS AND BLUE SHIELD

Following is a summary of benefits for each Anthem Blue Cross and Blue Shield administered plans.

IV. SUMMARY OF BENEFITS:

HEALTH MAINTENANCE ORGANIZATION (HMO)

Following is a summary of benefits for the regional HMO plan available in your area.

V. PREMIUM INFORMATION

Premiums are calculated based on the information provided in your Commonwealth of Virginia Health Benefits Group Program Application and supporting data.

PREMIUM DEVELOPMENT

The following medical rating pools are used to develop rates for the statewide self-funded Key Advantage plans as well as your group's demographics. Each employer group's premiums are developed based on the relationship of group-specific information to the pool norm for the appropriate rating geographical area.

Rating Pools

Rates for the self-funded plans are based on the following rating pools in addition to your group demographics.

- Community or pooled - group size of 1 through 49 employees

- Experience Rated

Group Size	Credibility Factor
50 - 99	41% of the group's medical experience
100 - 149	58% of the group's medical experience
150 - 199	71% of the group's medical experience
200 - 249	82% of the group's medical experience
250 - 299	91% of the group's medical experience
300 - 1500	100% of the group's medical experience

- Cost Plus – groups with more than 1500 employees

Key Advantage Outpatient Prescription Drug, Behavioral Health and Dental Premiums

In our self-funded plans with fewer than 1500 employees, premiums for the Outpatient Prescription Drug, Behavioral Health and Dental components are pool-rated based on the experience of the total TLC program, including all groups regardless of size. Costs for the pool's components are included in the rates provided in the statewide self-funded plans. Groups with more than 1500 employees will be underwritten on a cost plus basis.

Regional Health Maintenance Organization (HMO) Plan
Premiums for the Kaiser HMO plan are community rated. The size and demographic composition of an individual employer are not applicable.

High Deductible Health Plan
The HDHP is self-funded but will be pooled for all groups regardless of size.

Employer Contributions
Groups may select any combination of our plan offerings but the required minimum funding will be based on the un-weighted average single rate of the plans offered. For example if a group offers Key Advantage Expanded and Key Advantage 500, you would add the single rates for each and divide by two. The minimum requirement would then be 80% of the average single rate.

The Key Advantage required minimum employer contributions are:
Full Time Employees

- 80% of the average single employee premium rate
- 20% of the average additional dependent cost, if applicable *

Part Time Employees

- 40% of the average single employee premium rate
- 10% of the average additional dependent cost, if applicable *

*If 75% of all eligible employees enroll, the dependent contribution requirement is waived.

Minimum employer funding for HDHP is separate from the Key Advantage requirements. If the HDHP is offered, a Local Employer must pay 80% of single premium and 20% of the additional dependent premium.

RISK-SHARING POOL
There are excess claim limits included in the self-funded plans. Medical attachment points are $70,000 for groups with fewer than 300 participating employees; $90,000 for groups between 300 and 1000 participating employees; and for groups larger than 1000 an attachment point of $125,000 will apply. Excess claim limits are negotiable for groups with more than 1500 employees. The program self-funds these excess claims. The impact of this benefit is to spread the cost of catastrophic claims over the entire TLC program, sharing the risk among all of the member groups.

GROUP-SPECIFIC CLAIMS INFORMATION
Group-specific medical claims information for the Anthem Blue Cross and Blue Shield administered plans is available for employer groups with 50 or more enrollees. The cost for preparing the information will vary depending upon the

request. By providing this information on a by-request basis TLC can keep administrative costs low. The following ad hoc fee schedule describes the reports that are available and their cost. Contact your Anthem representative to request reports.

STANDARD AD HOC REPORTS FOR ANTHEM DATA
FOR THE LOCAL CHOICE GROUPS
50+ SEGMENT
(By written request)

As of 7/1/04 and 10/1/04, multiple vendors became involved in the TLC program. The reports below only capture **payments actually made by Anthem** and will capture all premiums paid. Anthem does not have claim information from the other vendors. Claims experience is not available from the other vendors as their products are pooled.

Report Description	Cost Per Report
I. Claims – claims by five digit group number providing monthly claims by type for the most recent 24 months Includes Large Claims Report – claims > $25,000 for last two years *Please indicate if a different 2 year time period is requested* This report is summary data and does not breakout data by subgroup	$200
II. Enrollment Summary – Enrollment by five digit group number by type membership providing monthly enrollment for the most recent 24 months *Please indicate if a different 2 year time period is requested* This report is summary data and does not breakout data by subgroup	$200
III. Annual claims and premium – 300+ rated groups can get the most recent 24 months (Local Choice specific) *Please indicate if a different 2 year time period is requested* This report is summary data and does not breakout data by subgroup	$100

***All claims are after discount.**

Payment method: Report requests must include the name and address of the person to bill. An invoice is generated by Finance and mailed to the group.

VI. HOW TO ENROLL

ADOPTING THE PROGRAM

An Adoption Agreement, Employer Data Sheet and HIPAA Memo of Understanding (MOU) must be completed to enroll in The Local Choice program. The Adoption Agreement acknowledges the rights, duties and responsibilities of the Department and the local employer. The Employer Data Sheet defines the plan(s) you have selected for adoption and confirms rates. The Memo of Understanding outlines responsibilities under the Health Insurance Portability and Accountability act.

Send your Adoption Agreement, Employer Data Sheet and MOU to:

The Local Choice Health Benefits Program
Commonwealth of Virginia
Department of Human Resource Management
101 North 14th Street, 13th Floor
Richmond, VA 23219

You may contact The Local Choice at (804) 786-6460 if you have questions about adopting the program.

The Department of Human Resource Management will send you written confirmation of the benefits and premiums, once approved.

ENROLLMENT

You may order enrollment packages as soon as the adoption information has been confirmed. The enrollment package includes a summary of benefits for each plan being offered, enrollment instructions and an Enrollment Form.

To enroll, each eligible employee and retiree (if covered) must complete an Enrollment Form. The Group Benefits Administrator is responsible for verifying the accuracy of each form before submitting it to the appropriate plan. Anthem Blue Cross and Blue Shield or Kaiser (if available) must receive completed Enrollment Forms no less than 30 days prior to the effective date of the program. Eligible employees that decline coverage must complete section C of the Enrollment Form to waive coverage.

VII. MEMBER FLYERS